

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 16, 2020

Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428

SUBJECT: SURVEY RESULTS

CCN: 245183

Cycle Start Date: Cycle Start Date: March 9, 2020

Dear Administrator:

### SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit <a href="https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0">https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0</a>.

### **SURVEY RESULTS**

On April 1, 2020, a survey was completed at your facility by the Minnesota Department of Health. The survey team completed a complaint investigation and a COVID-19 Focused Survey at North Ridge Health And Rehab to determine if your facility was in compliance with Federal requirements related to the complaint and implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

### PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 1, 2020 survey. North Ridge Health And Rehab may choose to delay submission of a

North Ridge Health And Rehab April 16, 2020 Page 2

POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Sarah Grebenc, Unit Supervisor Email: sarah.grebenc@state.mn.us

Fax: (651) 215-9697

### INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 1, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Sarah Grebenc, Unit Supervisor Email: sarah.grebenc@state.mn.us

Fax: (651) 215-9697

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

North Ridge Health And Rehab April 16, 2020 Page 3

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

North Ridge Health And Rehab may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

## QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <a href="https://qioprogram.org/">https://qioprogram.org/</a>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <a href="https://qioprogram.org/locate-your-qio">https://qioprogram.org/locate-your-qio</a>.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Missing

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/23/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  5430 BOONE AVENUE NORTH  NEW HOPE, MN 55428   (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
NORTH RIDGE HEALTH AND REHAB  (X4) ID PREFIX TAGGE TAGGET TAGGET TAGGET TAGGET   A COVID-19 Focused Infection Control survey was conducted 3/31/20, through 4/1/20, at your facility was in full compliance.  Because you are enrolled in ePOC, your signature is not required at the bottom of the electronic documents.  Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.  Food  On 3/31/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of the electronic documents.  Food  NITIAL COMMENTS  On 3/31/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of the first page of the CMS-2567 form.  Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.  Food  INITIAL COMMENTS  Food  Tagget  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION SHOWS (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION SHOWS (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PLAN OF CORRECTION SHOWS (EACH CORRECTION SHOW)  PREFIX TAGS  PROVIDER'S PR			245183	B. WING _		C <b>04/01/2020</b>
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  A COVID-19 Focused Infection Control survey was conducted 3/31/20, through 4/1/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations \$\frac{1}{2}\$ Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.  F 000  On 3/31/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to conduct a complaint investigation. Your facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following complaint was found to be SUBSTANTIATED with deficiencies cited:				<b>'</b> I	5430 BOONE AVENUE NORTH	
A COVID-19 Focused Infection Control survey was conducted 3/31/20, through 4/1/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance.  Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.  Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.  INITIAL COMMENTS  F 000  On 3/31/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to conduct a complaint investigation. Your facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.  The following complaint was found to be SUBSTANTIATED with deficiencies cited:	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLÉTION
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SUBSTANTIATED with deficiencies cited:		completed at your Department of Heat investigation. Your compliance with re 483, Subpart B, ar	facility by the Minnesota alth to conduct a complaint facility was found not to be in equirements of 42 CFR Part			
H5183228C deficiency cited at F623						
		H5183228C defici	ency cited at F623			
The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		signature is not repage of the CMS-2 correction is required facility acknowledges.	quired at the bottom of the first 2567 form. Although no plan of red, it is required that the			
A COVID-19 Focused Infection Control survey  ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE	4000:T0=		<u> </u>	NATUE -		0.00 5.475

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		LETED
		245183	B. WING _		04/0	; 1/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		2025
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F 000	Minnesota Departr compliance with §4 facility was in full of Because you are esignature is not recipage of the CMS-2 correction is require acknowledge receiption in the compart of an revisit of your facility that substantial conhas been attained verification.  Notice Requirement CFR(s): 483.15(c)(s) Notice Requirement CFR(s): 483.15(c)(s) Which is the reasons for the language and man facility must send a representative of the Long-Term Care Of (ii) Record the reasons for the language in the reasons discharge in the reasons for the language and man facility must send a representative of the Long-Term Care Of (iii) Record the reasons for the language in the reasons for the language and man facility must send a representative of the Long-Term Care Of (iii) Record the reasons for the language in the reasons for the language and man facility must send a representative of the Long-Term Care Of (iii) Record the reasons for the language in the reasons for the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the language and man facility must send a representative of the	sti/20, at your facility by the ment of Health to determine 483.80 Infection Control. The ompliance.  enrolled in ePOC, your quired at the bottom of the first 2567 form. Although no plan of es, it is required that the facilty ipt of the electronic documents.  acceptable electronic POC, a ty will be conducted to validate mpliance with the regulations in accordance with your  at Before Transfer/Discharge (3)-(6)(8)  the before transfer.  Insfers or discharges a y mustent and the resident's of the transfer or discharge and a move in writing and in a mer they understand. The acopy of the notice to a ne Office of the State embudsman.  Isons for the transfer or sident's medical record in aragraph (c)(2) of this section; notice the items described in finis section.	F 62			
	(ı) Except as speci	fied in paragraphs (c)(4)(ii) and				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  IG	COMPLETED		
		245183	B. WING _		C <b>04/01</b> /	/2020
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F 623	(c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of in be endangered un this section; (B) The health of in be endangered, un this section; (C) The resident's allow a more immedunder paragraph (C) An immediate required by the resunder paragraph (E) A resident has days.  §483.15(c)(5) Connotice specified in must include the focus (ii) The reason for (ii) The effective days.  §183.15(c)(5) Connotice specified in must include the focus (iii) The location to transferred or disconding the name and telephone numereceives such requite obtain an appear completing the form hearing request; (v) The name, additional control in the second con	In, the notice of transfer or a under this section must be at least 30 days before the red or discharged.  made as soon as practicable discharge when- ndividuals in the facility would der paragraph (c)(1)(i)(C) of andividuals in the facility would not paragraph (c)(1)(i)(D) of the least improves sufficiently to rediate transfer or discharge, c)(1)(i)(B) of this section; transfer or discharge is sident's urgent medical needs, c)(1)(i)(A) of this section; or not resided in the facility for 30 tents of the notice. The written paragraph (c)(3) of this section ollowing: transfer or discharge; which the resident is harged; the resident's appeal rights, e, address (mailing and email), more of the entity which uests; and information on how all form and assistance in m and submitting the appeal ress (mailing and email) and of the Office of the State	F 62	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB			, 5	STREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		C 01/20 <u>20</u>
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F 623	and developmental disabilities, the maitelephone number the protection and developmental disac C of the Developm and Bill of Rights A codified at 42 U.S. (vii) For nursing fact disorder or related email address and agency responsible advocacy of individes tablished under for Mentally III Individes the information in effecting the transfer must update the reas practicable once becomes available §483.15(c)(8) Notic In the case of facilities the administrator written notification to the State Survey State Long-Term C the facility, and the well as the plan for relocation of the re 483.70(I). This REQUIREME by:  Based on interview	illity residents with intellectual disabilities or related illing and email address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the efor the protection and luals with a mental disorder the Protection and Advocacy viduals Act.  Inges to the notice. In the notice changes prior to er or discharge, the facility cipients of the notice as soon et the updated information	F 623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB		, ,	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428	C <b>04/01/202<u>0</u></b>		
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F 623	process was follow notification of the redischarge location at the number for the residents (R1) who COVID-19, and wa facility.  Findings include:  The Ombudsman (telephone on 3/30/2R1 called OMB and member (FM)-A wa 3/21/20. R1 left the basket of laundry a facility though the fi use the back door have the back door when R1 reached the would not be allowed indicated she spoke and was told all resident would not building. OMB stated included if a resident would not building. OMB stated indicated R1 had the as the facility did not rights and/ or OMB identified she reques policy that included unapproved leave of the resident would not building that the facility did not rights and/ or OMB identified she reques policy that included unapproved leave of the resident would not building that included unapproved leave of the resident would not building that included unapproved leave of the resident would not building that included unapproved leave of the resident would not building that included unapproved leave of the resident would not building that included unapproved leave of the resident would not building that included unapproved leave of the resident would not building.	ed to include written eason for discharge, a and appeal rights to include ombudsman for 1 of 3 left the facility during s not allowed to return to the OMB) was interviewed via 20, at 2:32 p.m. and explained d informed OMB R1's family is outside of the facility on facility to bring FM-A one and then attempted to enter the ront door, however was told to by nursing staff. At that time the back door, R1 was told she and back into the facility. OMB are to the facility administrator didents received a policy that an it would be considered an an it would be considered an an eve (AMA) discharge and the be allowed back into the ed when R1 was immediately and/or a place to go. OMB are cab take her to the hospital of inform R1 of her appeal contact information. OMB ested a copy of the facility	F 623			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	COMPLETED
		245183	B. WING _		C <b>04/01/2020</b>
	PROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-\'L
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F 623	R1's quarterly Mini 1/14/20, identified diagnoses which ir anemia.  R1's Covid-19 Res Education effective was provided to R drop items off at the them up from there she was only to lea necessary appoint.  R1's Progress Note p.m. indicated R1 vinto two bags, whe was coming to pick R1 was educated to however stated shooff." R1 was seen a wheelchair headed reception area it w parking lot and R1 "outside and looke 6:06 p.m. the PN ir indicated R1 had be insisted R1 was be was at the laundry R1 was aware not indicated 15 minute R1 returned to the	mum Data Set (MDS) dated R1 had intact cognition and included paraplegia and sident, Family and Visitor a 3/20/20, identified education a regarding only have FM-A e front desk and R1 would pick at R1 indicated understanding ave the facility for a medical ment.  If (PN) dated 3/21/20, at 5:30 was found packing clothing in asked R1 reported FM-A aup the clothing for laundering. If quarantine process, a few minutes later in to the elevator. Once at the as noted a truck left the was not seen. Staff walked did around R1 was not seen. At indicated staff called FM-A who seen around the building and lack in the building while FM-A mat. FM-A further indicated to leave the building. The PN es after speaking with FM-A facility. Staff told R1 she could cility and was given her	F 62	3	
	included the follow	_			
	-Order dated 3/20/	20, indicated leave of absence			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  NG	COMPLETED	
		245183	B. WING _		C <b>04/01/2020</b>
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB			'	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-\ L
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F 623	are not approved edialysis. If the reside and Benefits and in they will not be abl. This only applies of for the Covid-19 paragraph of the Covid-19 paragraph. Order dated 3/21/discharge resident LOA in the wake of R1's Notice of Immedated 3/21/20, identification to discharge vious conduct of the safety and hear facility.  The administrator of 10:40 a.m. and expressions or the facility without appreturn to the facility pandemic. The adreducated and after approval on 3/21/2 discharged. The adon duty did not issued to the safety and start of the time of the condition of the safety and start of the time of the safety and start of the safety and saf	except for emergency care and dent insists please review Risk aform them, and or their family e to return to the community. Uring the national emergency andemic;  20, indicated Okay to will all medications following f Covid-19.  The diate Intent to Discharge and the letter was formal anarge R1 on 3/21/20, due to of R1 and her posed a threat to lith of other individuals in the letter was interviewed on 3/31/20, at colained the facility had a residents from their medical the dany resident who left the roval would not be able to a due to the Covid-19 ministrator stated R1 was releaving the facility without 0, R1 was immediately diministrator indicated the staff use the immediate discharge of discharge and further ailed to FM-A the following wed via telephone on 4/1/20, at the R1's care while at the	F 62	23	
	"unprofessional."	and the stall well			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB			,	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428		C 01/20 <u>20</u>
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F 623	telephone 4/1/20, a indicated she was laundry to FM-A ar recalled R1 did not immediately. RN-A FM-A was called w facility. RN-A stated came back to the falost around the builiner way back insidivalked around the that part of the stor administrator was discharge R1 since out of the building automatically discharged R1 with FM-A was coming did not verify. RN-A discharge form to get a since out of the building automatically discharged R1 with FM-A was coming did not verify. RN-A discharge form to get a since out of the building automatically discharged R1 with FM-A was coming did not verify. RN-A discharge form to get a since out of the building automatically discharged R1 with FM-A was coming did not verify. RN-A discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the building automatically discharge form to get a since out of the s	RN)-A was interviewed via at 1:17 p.m. and explained R1 going to go outside to drop off ad come back, however	F 623			
	F623 Policy effective would provide a resolution of an impendent when specific criteria policy included a refacility unless the stacility was endangular behavioral status as in the facility would The policy indicate representative would following informatic	er and/ or Discharge F622, we 1/2020, indicated the facility sident with a 30 day written ding transfer or discharge ria had not been reached. The esident would remain in the afety of individuals in the pered due to clinical or and/or the health of individuals otherwise be endangered. If the resident and/or and be provided with the con within the notice in writing manner they understand prior				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X4) PROVIDER/SURPLIED/CLIA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	-\L
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F 623	to transfer. The re the resident was of the resident's appo- address and telep	ason for the discharge, location lischarged to, a statement of eal rights including the name, hone number of the entity ch requests, the name, address	F 62	23	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 16, 2020

Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428

Re: State Nursing Home Licensing Orders

Event ID: 8BZ811

#### Dear Administrator:

The above facility was surveyed on March 31, 2020 through April 1, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

North Ridge Health And Rehab April 16, 2020 Page 2

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: sarah.grebenc@state.mn.us

Phone: (651) 201-3792

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Frig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/23/2020 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00238	B. WING		C 04/01/2020
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	04/01/2020
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2 000	Initial Comments		2 000		
	****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this corre pursuant to a surve found that the defi- herein are not corr not corrected shall with a schedule of	n Minnesota Statute, section ection order has been issued ey. If, upon reinspection, it is ciency or deficiencies cited rected, a fine for each violation be assessed in accordance fines promulgated by rule of partment of Health.			
Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result from orders provided the the Department with the D	a hearing on any assessments m non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.			
	conducted to deter licensure. Your fac	TS: bbreviated survey was rmine compliance of state cility was found to not be in the MN state licensure.			
	The following com substantiated: H51	plaint(s) were found to be 83228C			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

**Electronically Signed** 

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		) COM		(X3) DATE SURVEY COMPLETED	
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2 000	Continued From pa	age 1	2 000		
	signature is not rec page of state form orders are issued. electronic plan of o	lled in ePOC and therefore a quired at the bottom of the first. The following correction Please indicate your correction that you have der, and identify the date when ted.			
21925	MN St. Statute 144 Residents of HC F	1.651 Subd. 29 Patients & ac.Bill of Rights	21925		
	Residents shall no discharged. Residents writing, of the propits justification no I discharge from the before transfer to a This notice shall in contest the propose and telephone numon budsman pursuance, section 307(a) of this right, may conotice period ends shortened in situate control, such as a review, the accompresidents, a change treatment program resident's welfare, unless prohibited by programs paying for documented in the shall make a reason	fers and discharges. It be arbitrarily transferred or lents must be notified, in losed discharge or transfer and later than 30 days before the facility and seven days another room within the facility. It clude the resident's right to led action, with the address of the area nursing home leant to the Older Americans (12). The resident, informed thoose to relocate before the line. The notice period may be lions outside the facility's determination by utilization modation of newly-admitted to in the resident's own or another or nonpayment for stay by the public program or lor the resident's care, as medical record. Facilities onable effort to accommodate the out disrupting room			

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PRINTED: 04/23/2020 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED	
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NAME OF			STATE, ZIP CODE	
NORTH	RIDGE HEALTH AND REHAB	ONE AVENUE PE, MN 5542		
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PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETE BE APPROPRIATE DATE
21925	Continued From page 2	21925		
21925	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a proper discharge process was followed to include written notification of the reason for discharge, a discharge location and appeal rights to include the number for the ombudsman for 1 of 3 residents (R1) who left the facility during COVID-19, and was not allowed to return to the facility.  Findings include:  The Ombudsman (OMB) was interviewed via telephone on 3/30/20, at 2:32 p.m. and explained R1 called OMB and informed OMB R1's family member (FM)-A was outside of the facility on 3/21/20. R1 left the facility to bring FM-A one basket of laundry and then attempted to enter the facility though the front door, however was told to use the back door by nursing staff. At that time when R1 reached the back door, R1 was told she	21925		
	would not be allowed back into the facility. OMB indicated she spoke to the facility administrator and was told all residents received a policy that included if a resident left the facility for a			
	nonessential reason it would be considered an against medical leave (AMA) discharge and the resident would not be allowed back into the building. OMB stated when R1 was immediately discharged from the facility R1 called a cab due to not having a ride and/or a place to go. OMB			
	indicated R1 had the cab take her to the hospital as the facility did not inform R1 of her appeal rights and/ or OMB contact information. OMB identified she requested a copy of the facility policy that included AMA discharge for unapproved leave of absence (LOA), however			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
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21925	Continued From pa	ige 3		21925				
	the administrator har request.	ad not responde	ed to her					
	R1's quarterly Minimum Data Set (MDS) dated 1/14/20, identified R1 had intact cognition and diagnoses which included paraplegia and anemia.							
	R1's Covid-19 Resi Education effective was provided to R1 drop items off at the them up from there she was only to lea necessary appointr	3/20/20, identification regarding only the front desk and R1 indicated to the facility for	fied education have FM-A dR1 would pick understanding					
	R1's Progress Note p.m. indicated R1 v into two bags, when was coming to pick R1 was educated chowever stated she off." R1 was seen a wheelchair headed reception area it was parking lot and R1 "outside and looked 6:06 p.m. the PN in indicated R1 had b insisted R1 was ba was at the laundry R1 was aware not indicated 15 minute R1 returned to the not return to the face medications per ph	vas found packin asked R1 republic up the clothing of quarantine programmer was "just drope few minutes late to the elevator as noted a truck was not seen. So a dicated staff cate around" R1 word and the ck in the building mat. FM-A furth to leave the buildes after speaking facility. Staff tolecility and was givisician orders.	ing clothing orted FM-A for laundering. ocess, ping clothes iter in . Once at the cleft the Staff walked as not seen. At illed FM-A who building and ing while FM-A iter indicated lding. The PN g with FM-A d R1 she could ven her					
	R1's Order Summa included the following		3/31/20,					

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21925	Continued From pa	age 4	21925		
	are not approved edialysis. If the resident and Benefits and in they will not be abload This only applies of for the Covid-19 paragraph of the Covid	20, indicated Okay to will all medications following			
	The administrator 10:40 a.m. and expected and and after approval on 3/21/2 discharged. The according to the time of a the time o	was interviewed on 3/31/20, at plained the facility had a residents from their medical ted any resident who left the roval would not be able to y due to the Covid-19 ministrator stated R1 was r leaving the facility without 20, R1 was immediately dministrator indicated the staff ue the immediate discharge of discharge and further railed to FM-A the following wed via telephone on 4/1/20, at ted R1's care while at the and the staff were			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
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	Registered Nurse (telephone 4/1/20, a indicated she was laundry to FM-A ar recalled R1 did not immediately. RN-A FM-A was called w facility. RN-A stated came back to the foliate to the f	at 1:17 p.m. and going to go outs ad come back, he come back inside the stated after look ho indicated R1 d 15 to 20 minut acility and indicated buildings and was reasidents were "that meant they harged." RN-A in her medication back to pick up a stated there was in her stated the her stated there was in her stated the her stated	explained R1 side to drop off owever de king outside was still at the tes later R1 ated she got unable to find ed the staff had d not believe the directed to not allowed were dicated she is and thought R1, however as not ever said R1				
	The facility Transfe F623 Policy effecti would provide a re- notice of an impen- when specific crite	ve 1/2020, indica sident with a 30 ding transfer or	ated the facility day written discharge				
	policy included a refacility unless the sfacility was endang behavioral status a in the facility would The policy indicate representative would following informatic and language and	esident would re safety of individu pered due to clin and/or the health otherwise be end the resident and be provided won within the not	main in the lals in the lical or la of individuals indangered. Individuals ind				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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21925	to transfer. The re the resident was of the resident's approaddress and telep which receives sur and telephone nur  SUGGESTED ME administrator, dire designee could re procedures that w to the resident and transfer. The facili policies and audit these audits will be assessment comn	ason for the discharge, location ischarged to, a statement of eal rights including the name, hone number of the entity ch requests, the name, address	21925			

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 16, 2020

Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428

SUBJECT: SURVEY RESULTS

CCN: 245183

Cycle Start Date: Cycle Start Date: March 9, 2020

Dear Administrator:

### SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit <a href="https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0">https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0</a>.

### **SURVEY RESULTS**

On April 9, 2020, a survey was completed at your facility by the Minnesota Department of Health. The survey team completed a complaint investigation at North Ridge Health And Rehab to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

### PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 9, 2020 survey. North Ridge Health And Rehab may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your

North Ridge Health And Rehab April 16, 2020 Page 2

allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Susanne Reuss, Unit Supervisor

Fax: (651) 215-9697

Email: susanne.reuss@state.mn.us

### **INFORMAL DISPUTE RESOLUTION**

You have one opportunity to dispute the deficiencies cited on the April 9, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Susanne Reuss, Unit Supervisor

Fax: (651) 215-9697

Email: susanne.reuss@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

North Ridge Health And Rehab April 16, 2020 Page 3

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

North Ridge Health And Rehab may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

### QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <a href="https://qioprogram.org/">https://qioprogram.org/</a>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <a href="https://qioprogram.org/locate-your-qio">https://qioprogram.org/locate-your-qio</a>.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/23/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	04/0	J9/20 <u>20</u>
NORTH I	RIDGE HEALTH AND	REHAB		430 BOONE AVENUE NORTH IEW HOPE, MN 55428		
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F 000	INITIAL COMMEN	TS	F 000			
	completed at your investigation. Your	, an abbreviated survey was facility to conduct a complaint facility was found not to be in 2 CFR Part 483, Requirements e Facilities.				
	substantiated:	plaints was found to be 5183230C. Deficiency issued				
	as your allegation of Department's acceeding enrolled in ePOC, at the bottom of the form. Your electron	of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will attion of compliance.				
F 623 SS=D	an on-site revisit of conducted to validation with the regulation accordance with you Notice Requirement	nts Before Transfer/Discharge	F 623			
	resident, the facility (i) Notify the reside representative(s) of the reasons for the language and man facility must send a	nsfers or discharges a y must- ent and the resident's if the transfer or discharge and in a move in writing and in a iner they understand. The a copy of the notice to a ine Office of the State				

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y4) PROVIDER/SUBBLIEB/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		C <b>04/09/2020</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	<b>√</b> L
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLÉTION
F 623	(ii) Record the readdischarge in the reaccordance with pand (iii) Include in the reparagraph (c)(5) or \$483.15(c)(4) Timi (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of in be endangered unthis section; (B) The health of in be endangered, unthis section; (C) The resident's allow a more immedunder paragraph (c) An immediate required by the resunder paragraph (c) A resident has days.  §483.15(c)(5) Connotice specified in must include the for (i) The reason for (ii) The effective days (iii) The location to transferred or discontinuation of the control of the con	sons for the transfer or sident's medical record in aragraph (c)(2) of this section; notice the items described in f this section.  In this section.  In gof the notice. In paragraphs (c)(4)(ii) and the notice of transfer or l under this section must be at least 30 days before the red or discharged.  In the notice of transfer or l under this section must be at least 30 days before the red or discharged.  In the facility would der paragraph (c)(1)(i)(C) of long the later transfer or discharge, c)(1)(i)(B) of this section; transfer or discharge is sident's urgent medical needs, c)(1)(i)(A) of this section; or not resided in the facility for 30 letents of the notice. The written paragraph (c)(3) of this section ollowing: transfer or discharge; ate of transfer or discharge; which the resident is	F 62	23	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB		1 5	STREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		C 09/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	and telephone numreceives such requito obtain an appear completing the form hearing request; (v) The name, additelephone number Long-Term Care O (vi) For nursing fact and developmental disabilities, the matelephone number the protection and developmental disabilities of the Developmental disabilities and addisorder or related email address and agency responsible advocacy of individes advocacy of ind	and and an	F 623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 430 BOONE AVENUE NORTH NEW HOPE, MN 55428		C 09/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	the facility, and the well as the plan for relocation of the red 483.70(I). This REQUIREMEI by: Based on interview facility failed to ensprocess for 1 of 3 refacility during COV return to the facility. Findings include: R1's diagnoses obtox Record dated 4/7/2 visual loss, major of diabetes. R1's discharge Min 3/23/20, identified In R1's care plan dated discharge plans we homeless before an On 4/7/20, at 11:21 interview, the relocation case volunteers who asswere not allowed a restrictions, a friend and read it for him. indicated R1's friend because R1 is blind the relocation of the relocation of the relocation of the relocation case volunteers who asswere not allowed a restrictions, a friend and read it for him. indicated R1's friend because R1 is blind	are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at §  NT is not met as evidenced and document review, the sure a proper discharge esidents (R1) who left the ID-19, and was not allowed to a cained from the Admission concluded low back pain, depressive disorder and type 2 simum Data Set (MDS) dated R1 had intact cognition and and 10/25/19, indicated ere unknown due to R1 being	F 623			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE HEALTH AND REHAB		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 6430 BOONE AVENUE NORTH NEW HOPE, MN 55428		C 09/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	beyond the propert worker stated she whad opened the do towards his friend. he went to his friend when he came back he had violated the rules. The relocation was not aware if R about the conseque and that R1 was not after he was inapprescible.  On 4/7/20, at 11:36 kicked me out. I amfurther stated "I had that had not been not help read my may when the virus camber come in to read my mine came to the front prescible a few thing door, the reception and she let me out in the front parking me." R1 then stated facility my stuff was told I was being distinct the chairs, in the night, into the next mobility at about 10 and I went to Salvanever left the property.	was told if he did not to go y it was okay. The relocation was informed the receptionist or for R1 and directed him R1 then indicated to her that d's car to review the mail and k to the building he was told facility COVID-19 restriction on worker further indicated she had received information ences of leaving the property of given medication and shelter copriately discharged from the  a.m. R1 stated "they [facility] had four or five months of mail ead, they gave me a volunteer had out, that person couldn't mail anymore. So a friend of facility, he called and said I am g to pull into the parking lot, h, will they let you out, so I gs and went through the front ist got up to open the door, hand I went and sat in his car lot and he read the mail to d "when I came back into the sisting on a dolly and I was his charged, I'm blind, I had to sit front entrance, I sat there all morning, I called metro hand. Army." R1 further stated "I erty, when I got out of the car, he in. I don't even have my	F 623			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	IPLE CONSTRUCTION  NG	COMPLETED	
		245183	B. WING _		C <b>04/09/2020</b>
	PROVIDER OR SUPPLIER	REHAB			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTION
F 623	medications, they of They [facility staff] they were suppose and I would be told nurse's and nursing read my mail."  On 4/7/20, at 1:00 indicated that R1 re COVID-19 is, hand gatherings, visitor had any questions administrator further assessment we edif R1 was to leave further indicated the R1 was discharged involved in that." That "I believe [R1] because that has be know that for certa sent with." The adrilooking in the prognoted [referring to The administrator to is that he was goint that he left the facility because them a richard a ride, we would rive a ride, we would review of the meditat upon the abruitments.	did not give me any of them. wouldn't read my mail to me, ed to, I'd ask, can you read this I, this is not my job. The g assistants were too busy to p.m. the administrator ecceived education on what I hygiene, risk with community limitations and was asked if he	F 62	23	
		discharge instructions of after			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245183	B. WING _		C <b>04/09/2020</b>
	PROVIDER OR SUPPLIER	REHAB		~\ L	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 623	(DON) indicated the the discharge. The knew because of sigiven his medication that her expectation nursing note of information instructions, medicated to the facility between but when she left to the facility waiting that the evening sumedication list and indicated that staff note about the discompleted it.  On 4/7/20, at 1:54 stated "he [R1] was p.m. and he was a facility administrate was print his [R1] remember, has belongings and pur remember if I wroten normally write a not discharged when I that R1 was still sit when he was leaving the stated in the was leaving the completed in the thought may be the completed it.	p.m. the director of nursing at she was not present during DON also indicated that she peaking with staff that R1 was ons. The DON further indicated ns was that staff would make a formation such as discharge ations and medications list		23	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245183	B. WING _		C <b>04/09/2020</b>	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 BOONE AVENUE NORTH NEW HOPE, MN 55428	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLÉTION	
F 623	that R1 was still sit RN-A then further doesn't call the ge and [R1] said he is called the administ shift."  On 4/7/20, at 2:35 was not him that h facility when he wanot have given R1 He further stated that lived in the start.  The facility Transfer approved 1/2020 in representative will information within language and man transfer: reason fo which the resident discharged. The period of the start well with the start when staff well well and when staff well.	estated "I asked [R1] why he estated "I asked [R1] why he estated "I asked [R1] why he estated that was here earlier, a not picking up my calls. I trator before the end of my p.m. R1's nephew stated it ad picked R1 up from the estate discharged and he would a ride as he lived out of state. Here were no other relatives attended that would have assisted that would have assisted er and/or Discharge Policy last endicated the resident, and/or be provided with the following the notice, in writing and the notice, in writing and the ransfer and the location to its being transferred or colicy failed to address where the supposed to document the ton and any pertinent	F 62	3		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 16, 2020

Administrator North Ridge Health And Rehab 5430 Boone Avenue North New Hope, MN 55428

Re: State Nursing Home Licensing Orders

Event ID: FVGW11

#### Dear Administrator:

The above facility was surveyed on April 7, 2020 through April 9, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

North Ridge Health And Rehab April 16, 2020 Page 2

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susanne Reuss, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

North Ridge Health And Rehab April 16, 2020 Page 3

PRINTED: 04/23/2020 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE				
		00238	B. WING		04/0	9/2020
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADD		DDRESS, CITY, S	STATE, ZIP CODE		
NORTH	RIDGE HEALTH AND RE	HAB	ONE AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENT	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be	innesota Statute, section on order has been issued If, upon reinspection, it is ney or deficiencies cited red, a fine for each violation assessed in accordance es promulgated by rule of timent of Health.				
	corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Life-inspection with any result in the assessment	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to e items will be considered ack of compliance upon vitem of multi-part rule will ent of a fine even if the item ng the initial inspection was				
	that may result from norders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.				
	to determine compliar following correction or indicate on your elect	: ), a survey was conducted nce for State licensure. The rders are issued. Please ronic plan of correction that e order, and identify the				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

**Electronically Signed** 

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
		00238	B. WING	FINIA	C <b>04/09/202<u>0</u></b>			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE				
NODTU	NORTH RIDGE HEALTH AND REHAB 5430 BOONE AVENUE NORTH							
NOKIHI	NEW HOPE, MN 55428							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)				
2 000	Continued From pa	ge 1	2 000					
	substantiated:	plaints were found to be 5183230C. Deficiency was 1925.						
	signature is not req page of state form. is required, it is req	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility of the electronic documents	ı					
21925	MN St. Statute 144 Residents of HC Fa	.651 Subd. 29 Patients & ac.Bill of Rights	21925					
	discharged. Reside writing, of the proposits justification no lad discharge from the before transfer to a This notice shall incontest the propose and telephone numombudsman pursua Act, section 307(a) of this right, may chnotice period ends. shortened in situation control, such as a creview, the accommersidents, a change treatment program, resident's welfare, cunless prohibited by programs paying for documented in the	be arbitrarily transferred or ents must be notified, in used discharge or transfer and ater than 30 days before a facility and seven days nother room within the facility clude the resident's right to ed action, with the address aber of the area nursing home ant to the Older Americans (12). The resident, informed anose to relocate before the The notice period may be one outside the facility's determination by utilization modation of newly-admitted as in the resident's medical or the resident's own or another or nonpayment for stay by the public program or or the resident's care, as medical record. Facilities nable effort to accommodate						

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health STATE FORM

FVGW11 If continuation sheet 2 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION INTERCATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00238	B. WING		C 04/09/2020	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	04/00/202 <u>0</u>	
NORTH	RIDGE HEALTH AND	REHAB	NE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLE E APPROPRIATE DATE	
21925	Continued From pa	age 2	21925			
	assignments.					
	by: Based on interview facility failed to ensprocess for 1 of 3 r	ent is not met as evidenced  y and document review, the gure a proper discharge residents (R1) who left the ID-19, and was not allowed to				
	Findings include:					
	Record dated 4/7/2	tained from the Admission 20, included low back pain, depressive disorder and type 2				
	3/23/20, identified R1's care plan date	nimum Data Set (MDS) dated R1 had intact cognition and ed 10/25/19, indicated ere unknown due to R1 being dmitting to facility.				
	interview, the reloc she had found out facility because he The relocation cas volunteers who ass were not allowed a restrictions, a frien and read it for him. indicated R1's frier because R1 is blind person he was going the parking lot and beyond the propert worker stated she	l a.m., during a telephone ration case manager indicated that R1 was kicked out of the violated the lockdown rules. The relocation worker further and came to the facility and the fold the front desking to meet with his friend in was told if he did not to go by it was okay. The relocation was informed the receptionist for for R1 and directed him				

6899

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
							C
_		00238		B. WING			09/202 <u>0</u>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NORTH	RIDGE HEALTH AND	REHAR		NE AVENUE			
				PE, MN 5542			1
(X4) ID PREFIX TAG		ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21925	Continued From pa	age 3		21925			
	towards his friend. he went to his friend when he came back he had violated the rules. The relocation was not aware if R about the consequent that R1 was not after he was inapplifacility.	d's car to revieun d's car to revieun de facility COVID on worker further 1 had received ences of leaving to given medica	w the mail and g he was told -19 restriction er indicated she information g the property tion and shelter				
	On 4/7/20, at 11:36 kicked me out. I an further stated "I had that had not been into help read my may when the virus can come in to read my mine came to the front parking they won't let me in grabbed a few thindoor, the reception and she let me out in the front parking me." R1 then state facility my stuff was told I was being dis in the chairs, in the night, into the next mobility at about 10 and I went to Salva never left the proper they wouldn't let medications, they of They [facility staff] they were suppose and I would be told nurse's and nursing the state of the state of the suppose and I would be told nurse's and nursing the state of the sta	In living at the Had four or five more ad, they gave all because I am ne out, that person mail anymore. I acility, he called g to pull into the grand went through and I went and I went and I went and I went I came a sitting on a doscharged, I'm blater front entrance, morning, I called a.m., who can ation Army." R1 erty, when I got e in. I don't eve wouldn't read mad to, I'd ask, can, this is not my	oliday Inn." R1 onths of mail me a volunteer in blind, but son couldn't So a friend of d and said I am e parking lot, ou out, so I rough the front en the door, d sat in his car d the mail to e back into the olly and I was ind, I had to sit it I sat there all ed metro ine and got me, further stated "I out of the car, in have my any of them. in you read this job. The				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/ IDENTIFICA	/SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
	00238						C <b>09/202<u>0</u></b>
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY, S	TATE, ZIP CODE			
NORTH	RIDGE HEALTH AND	REHAB		ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETE DATE
21925	Continued From pa	age 4		21925			
	read my mail."						
	On 4/7/20, at 1:00 indicated that R1 rd COVID-19 is, hand gatherings, visitor I had any questions administrator further assessment we ed if R1 was to leave further indicated th R1 was discharged involved in that." That "I believe [R1] because that has because that has because that has because that has because that he prognoted [referring to The administrator to is that he was goin that he left the facil nephew." When as way of the facility be administrator explain can give them a richave a ride, we would receive the medications (amount with directions and care in the communications). The knew because of siven his medications	eceived educal hygiene, risk imitations and or comments. er indicated that ucated on what the facility. The at he did not ke at and stated he administration was sent with been our praction, if the medication, if the medication hen stated "mig to his nephelity at [4:56 p.n ked if R1 had between the doubt at [4:56 p.n ked if R1 had between the dined, "We gentle somewhere uldn't let that he ical record lactor discharge, Fant provided), a discharge insinity.  p.m. the direct at she was no DON also ind peaking with s	ation on what with community was asked if he The at during the at would happen e administrator know what time I "I was not for then indicated his medication ice, but I don't cations were a stated "I was d I don't see it as being sent]." y understanding ew's home and in.] with his slept in the entry bors, the herally ask if we if they don't happen."  ked evidence R1 had received a medication list tructions of after tor of nursing t present during licated that she staff that R1 was				

Minnesota Department of Health

STATE FORM 6899 FVGW11 If continuation sheet 5 of 7

AND DLAN OF CORRECTION INTERCATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI  A. BUILDING:		
	00238	B. WING			C <b>09/2020</b>
NAME OF I			STATE, ZIP CODE		<u> </u>
		OONE AVENUE			
NOKIII	NEW H	OPE, MN 5542			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21925	Continued From page 5	21925			
	that her expectations was that staff would make nursing note of information such as discharge instructions, medications and medications list given to R1 upon discharge.  On 4/7/20, at 1:46 p.m. license practical nurse (LPN)-A indicated that R1 was discharged from the facility between four and five p.m. on 3/23/2 but when she left the facility after her shift at 10:30 p.m., R1 was still sitting in the entryway of the facility waiting for a ride. LPN-A also indicate that the evening supervisor gave R1 medication medication list and instructions. LPN-A further indicated that staff would document in the nurse note about the discharge and that she did not make a note of the discharge because she thought maybe the evening supervisor had completed it.	0, f ed s,			
	On 4/7/20, at 1:54 p.m. registered nurse (RN)-A stated "he [R1] was discharged, I came in at 3 p.m. and he was already discharged by the facility administrator." RN-A then stated "all I did was print his [R1] medication list, contacted a family member, had an aide pack R1's belongings and put them on a cart. I can't remember if I wrote a note." RN-A then stated "normally write a note but he was already discharged when I got here." RN-A then indicate that R1 was still sitting in the lobby at 11:30 p.m when he was leaving the facility after his shift at that he had called the administrator and told hir that R1 was still sitting there, trying to find a ride RN-A then further stated "I asked [R1] why he doesn't call the gentlemen that was here earlier and [R1] said he is not picking up my calls. I called the administrator before the end of my shift."	ed nd n			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,	or connection	I DENTILION TO THE MEDICAL	A. BUILDING:			
00238			B. WING	-	C 04/09/202 <u>0</u>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
NORTH I	RIDGE HEALTH AND	REHAR	ONE AVENUE PE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETE THE APPROPRIATE DATE	Ē
21925	Continued From pa	age 6	21925			
	was not him that h facility when he wa not have given R1 He further stated the	p.m. R1's nephew stated it ad picked R1 up from the as discharged and he would a ride as he lived out of state. here were no other relatives ate that would have assisted				
	approved 1/2020 in representative will information within a language and man transfer: reason fo which the resident discharged. The poand when staff were	er and/or Discharge Policy last ndicated the resident, and/or be provided with the following the notice, in writing and mer they understand, prior to r transfer and the location to is being transferred or olicy failed to address where re supposed to document the on and any pertinent the discharge.				
	administrator, direct designee could reversely procedures that we to the resident and transfer. The facilit policies and audit puthese audits will be assessment commendations.	THOD OF CORRECTION: The ctor of nursing (DON), or view and/or develop policy and itten notification was provided their representative before a cy could educate staff on these periodically. The results of e reviewed by the quality littee to ensure compliance.  R CORRECTION: Twenty One				

6899